Commissioning maternity care:

little room for manoeuvre?

At the time of writing, the Bill set to 'reform' the NHS is shortly to be debated in the House of Commons. Gazing into the uncertain future, it seems inescapable that GPs in England will collectively be taking on at least part of the responsibility for commissioning medical care. In this month's *BJGP*, three papers, all studying different aspects of maternity care, illustrate some of the questions that commissioners are going to have to grapple with when that happens.

ADHERENCE TO GUIDELINES

Pierce and colleagues report a study where clinicians were asked about their follow-up of women who had experienced gestational diabetes mellitus.¹ Not surprisingly, the authors identified considerable variety in practice, and found that the guidelines from the National Institute for Health and Clinical Health (NICE) were not being followed consistently.

Non-compliance with authoritative guidelines is a familiar finding, and such a conclusion raises again the vexed question of precisely what guidelines are, and how far clinicians are expected to follow them.² The question will still be a live one for clinicians, though it may not trouble commissioning groups much. Where NICE gives very clear instructions it is very likely that they will be followed to the letter in commissioning contracts. The particular guidelines that are the starting point for this study include specific recommendations for gestational diabetes: not to screen routinely by urine analysis for glucose; also for a 6-week follow-up with a single fasting blood glucose and not a glucose tolerance test. They should therefore be welcomed, since they limit activity rather than encourage more.³

NICE has also issued guidelines on antenatal care.⁴ In contrast, these highly

specific and positively prescriptive lists set out in precise detail exactly what should take place at every stage in pregnancy. There is little to take exception to. While the positive instructions seem utterly sensible, and synthesise all the most recent evidence on what should be done, they also include a surprisingly long and welcome list of activities that should be avoided, such as pelvic and breast examination.

In passing, they also illustrate the general concern of the way that guidelines seem to set current practice in stone. For instance they advise against regular weighing. Had such authoritative guidelines been written perhaps 30 years ago, when regular weighing was a standard component of every antenatal visit, perhaps the research that undermined it might never have been done, and we would still find ourselves carrying out what is now considered a pointless element of antenatal care.

The question that this very detailed set of guidelines poses for commissioners is how much scope they will have to decide the content of anything. As the evidence for certain practices, or interventions, or pathways becomes clearer, it is quite possible that the decisions will be made as centrally as before, even if it is being made by a body working independently from the Department of Health. One could argue that this is right and proper: the system will become a mechanism for implementing best practice throughout the country, ending both unacceptable variation and postcode lotteries, while perhaps regrettably giving the lie to local decision making.

ECONOMICS OF SCREENING

If commissioners will be unable to vary the content of care, there will surely be scope to negotiate on price. Also in this month's journal, Bryan *et al* present the economic analysis of early screening for thalassaemia and haemoglobinopathies.⁵ Previous papers from this study had established that three-quarters of all women consulted for

pregnancy before 10 weeks' gestation, but that fewer than 5% had received screening by that time.⁶ Introducing two different models where screening was offered at the first consultation, and before the midwife booking consultation, increased the proportion screened by 10 weeks from 2% to 24% and 28%.⁷ Here they conclude that the additional benefit which results from earlier screening comes at a cost of £13 per woman screened. This throws the commissioning decision into sharp relief. The commissioning body will have to consider whether this is the best way of spending that money, or whether it could be put to better use elsewhere, and forgo the benefits of earlier screening for thalassaemia and haemoglobinopathies.

As it happens, the recommendation for earlier screening has already been incorporated into the NICE antenatal care guideline,⁴ and commissioners may not have the freedom to consider the additional cost. The Bryan *et al* paper does, however, illustrate that commissioning will often lead to a conflict between hard, quantifiable costs, and more nebulous measures of quality; and reminds us of the fear that whenever that happens low cost will usually trump higher quality.

PRICE OF CONTINUITY

The third paper by Smith illustrates how it may be possible in future to counter such a move towards the 'cheap and cheerful' end of medical care. Smith has identified all the elements of postnatal care that matter to the mothers, and has constructed a questionnaire to assess the quality of care.⁸ Its importance lies in the way that it sets out to cover all aspects of postnatal care, and focuses on what matters to patients. At the same time, identifying the different elements of care and assessing each one separately, as this questionnaire does, raises another question that will be familiar to anyone who has lived through the last 10 years of primary care in the UK. Within maternity

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care, some tasks require the skills of highly-trained midwives or doctors; others might be carried out by staff at a lower level. So, to take the most obvious example, measuring blood pressure and testing urine could be delegated to care assistants.

The cheapest way of organising antenatal care might be a centralised facility employing a small number of highly-skilled midwives managing a larger number of care assistants and midwives in training, and numerous pregnant women being seen. Such a model is already being introduced on a limited scale postnatally, where care assistants are taking on some of the tasks traditionally completed by midwives. Here the casualty could be the relationships that pregnant women develop with midwives, and value enormously. An organisation offering such a structure would directly pose a question that GPs as clinicians have been unwilling to ask about their own care, namely the price that they would be prepared to pay for personal continuity. The NICE guidelines on antenatal care do recommend continuity of care, which might restrain those going all out for the skill-mix approach. On the other hand, they define it as care by 'the same small team of caregivers', which might allow plenty of room for interpretation, and perhaps cost savings, by cash-strapped commissioners.⁴

DEFINING ROLES AND INTEGRATION

The final part of the commissioning puzzle is the allocation of responsibility for different components of care. Maternity care has been better organised in this sense than many other areas of medicine. The need for clear delineation is underlined by the study by Pierce and colleagues which found uncertainty over personal responsibility for follow up after gestational diabetes. Almost 40% of practices did have a protocol for the care of women with gestational diabetes mellitus, but only a third had been agreed with secondary care. Almost all the secondary care responders had a protocol, but few had shared them outside the hospital.¹ This particular element should be a simple one to sort out, but again it raises a bigger question. In particular, will GPs as commissioners seek to increase what they

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do as clinicians in order to keep the costs of midwifery care to the minimum? Which, apart from putting into sharp relief the kind of conflicts of interest that are likely to become the stuff of everyday professional life, also underlines how important it will be to ensure seamless integration between primary and secondary care providers. Here, as others have argued, integration and cooperation will turn out to be much more important than competition.

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